

ANIMAL BITE INTAKE REPORT

Communicable Disease Reporting System (CDRS)
Columbus Public Health & Franklin County Board of Health

PLEASE FAX THIS REPORT WITHIN 24 HOURS TO:
FAX (614) 719-8890

Ohio Administrative Code 3701-3-28 states: "Whenever a person is bitten by a dog or other mammal, report of such bite shall be made within 24 hours to the health commissioner of the district in which such bite occurred."

TO BE COMPLETED BY THE TREATING FACILITY

FACILITY NAME: _____ PHYSICIAN: _____
ADDRESS: _____ CITY: _____ ZIP CODE: _____
PHONE#: _____ RABIES POST EXPOSURE TREATMENT STARTED? ☐ NO ☐ YES

Please complete as much information as possible.

VICTIM (PERSON INJURED)

DATE OF INJURY: ____/____/____
VICTIM'S NAME: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE#: (HOME) _____ (WORK) _____ (CELL) _____
SEX: ☐ MALE ☐ FEMALE AGE: _____ TYPE OF INJURY: ☐ BITE ☐ SCRATCH ☐ BRUISE ☐ OTHER
LOCATION OF INJURY(IES) ON BODY: _____
WAS THE VICTIM INJURED... ☐ ON THE ANIMAL OWNER'S PROPERTY OR ☐ OFF THE ANIMAL OWNER'S PROPERTY
PARENT/GUARDIAN (if under 18): _____
ADDRESS (if different than victim): _____ PHONE#: _____

ANIMAL

ANIMAL TYPE: ☐ DOG ☐ CAT ☐ FERRET ☐ BAT ☐ RACCOON ☐ SKUNK ☐ OTHER _____
ANIMAL COLOR: _____ BREED: _____ ANIMAL NAME: _____
WHERE IS THE ANIMAL NOW? _____ STRAY ANIMAL? ☐ YES ☐ NO
DO YOU BELIEVE THE ANIMAL IS VACCINATED FOR RABIES? ☐ YES ☐ NO
RABIES TAG # (if known) _____ VETERINARIAN/CLINIC: _____

OWNER or LOCATION OF ANIMAL

If the animal owner is not known, please indicate in the address section where the injury occurred (i.e. street or nearest intersection)

OWNER'S NAME: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE#: (HOME) _____ (WORK) _____ (CELL) _____